

# Core 400 LLC

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**DATE NOTICE SENT TO ALL PARTIES:** Apr/15/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** caudal epidural steroid injection

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Orthopedic Surgery

**REVIEW OUTCOME:** Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is the opinion of the reviewer that the request for caudal epidural steroid injection is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. The mechanism of injury is described as lifting. EMG/NCV dated 02/06/14 is reported to be a normal electrodiagnostic study. Discharge summary dated 01/02/15 indicates that the patient completed 160 hours of chronic pain management program. Office visit note dated 02/20/15 indicates that the patient complains of pain in his back radiating into his legs. Current medications are Celebrex, Medrol Pak, promethazine, cyclobenzaprine, hydrocodone-acetaminophen, gabapentin and tizanidine. The patient reports he is frustrated and he has not had much treatment. MRI of the lumbar spine dated 03/17/15 revealed mild stenosis of the lateral recesses at L4-5 due to a protruding disc and facet hypertrophy. There is no lumbar spinal canal or neural foraminal stenosis.

Initial request for caudal epidural steroid injection was non-certified on 03/09/15 noting that electrodiagnostic studies were reported as normal. The MRI was not provided for review. The patient has undergone some therapy and a chronic pain management program. There was no indication that the claimant had not been responsive to the conservative treatment provided to date. The denial was upheld on appeal dated 03/19/15 noting that there is no updated MRI for review. The last exam note was from February 2015. There was a peer note stating that epidural steroid injection was approved; however, the last exam note stated that the treating provider wanted to order a new MRI to assess why the patient had weakness and sensory changes. There was no formal comprehensive exam of the lower extremities and back to include reflex, motor or sensory changes. The prior EMG/NCV was negative for radiculopathy.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries on xx. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. There is no current, detailed physical examination submitted for review with findings of radiculopathy as required by the Official Disability Guidelines. The submitted EMG/NCV is a normal study and the

submitted MRI fails to document any significant neurocompressive pathology. Additionally, the patient completed a chronic pain management program in January 2015 which indicates a finding that the patient had failed lower levels of care. As such, it is the opinion of the reviewer that the request for caudal epidural steroid injection is not recommended as medically necessary and the prior denial is upheld.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

☐ ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)